Exhibit B

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

IN RE BARD IVC FILTERS PRODUCTS LIABILITY LITIGATION,

NO. MD-15-02641-PHX-DGC

DO NOT DISCLOSE

SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

VIDEOTAPED DEPOSITION

- of -

CHRISTOPHER S. MORRIS, M.D.

taken on behalf of the Plaintiffs on Tuesday, July 25, 2017, at the Courtyard by Marriott, 25 Cherry Street, Burlington, Vermont, commencing at 9:08 AM.

VIDEO TECHNICIAN: DEVYN MULHOLLAND

COURT REPORTER: JOHANNA MASSÉ, RMR, CRR

A. Yes.

Q. What level of certainty did you apply to your opinions?

MR. ROGERS: Object to the form.

You can respond.

A. I don't know really how to answer that question. I think that's more of a legal term, as far as I can tell, but I approached this litigation the same way I practice interventional radiology on a daily basis. I always seek the truth, number one. I use many factors to help render my opinions. That includes first and foremost my personal experience, which I consider large. I also review the medical literature, the pertinent medical literature, of which there's not a lot of Level I or Level II evidence related to IVC filters, unfortunately, and I'm -- I'm part of that problem. I've contributed to the Level III and below evidence as well.

But I still use the literature to help me make -- make these decisions. I attend national meetings, talk with colleagues, participate in journal clubs, and honestly rely a lot on the FDA to -- to help make these decisions as well. So there are lots of different factors that go into it.

Q. Right. So --

A. My -- I approach the litigation using the same -- same methodology, essentially. So I would say a high level of certainty.

Q. Right. So I understand your answer was mostly about your methodology, your approach, what things you -- how you approach reaching a decision, and I'm -- and I think the last part of your answer where you said "so I would say a high level of certainty," that's really what I was getting after with my question is what level of certainty, and you said a high level of certainty.

So my question follow-up on that is, Did you --

A. I was going to say the reason I said all those is because if I just relied on a hunch or what my pulmonology colleague told -- told me that had never placed a filter in his life, that methodology would lead me to have less of a high level of certainty.

Q. Of course.

A. I might have a low -- so that's why I had to give you the background on how I know that I reached a high level of certainty in my opinions.

Q. Yes. And so if you were to put a numerical

quantification to "high level of certainty," would it be -- what would it be, approximately?

MR. ROGERS: Object -- object to the form.

A. That is a very difficult question to answer, quant- --

Q. You're getting paid $500 an hour to answer hard questions.

A. Well, yeah.

MR. ROGERS: Object to the form. That's not the definition --

MR. ROTMAN: I'll strike that.

MR. ROGERS: -- of what makes a question acceptable.

MR. ROTMAN: I'll strike that. I'll strike that.

Q. Maybe you can't answer it.

A. I mean, you know, the -- so --

Q. What level of --

A. -- I have to -- I have to answer that difficult question with a difficult answer. And, you know, we were talking on a break a little while ago about memory issues. My -- my benchmark for 100 percent certain medical science, so to speak my touchstone, is my brother, who I'm very close to, who's

a top ten neuroscience researcher specializing in Alzheimer's and memory disorders, so I gauge that as being 100 percent certain. He has $50 million in grants. He's the quintessential medical scientist that relies on Level I and Level II evidence. So when I compare his body of work, which I know -- which I've been following my entire life -- again, he's -- you know, he's very close to me and -- and I really respect his degree of scientific validity. When I compare that to the literature that's available regarding IVC filters, there's basically no -- no comparison, so how can I make 100 percent certain opinions based on literature which is less than Level I or Level II evidence?

Q. Understood. And -- and so nevertheless, you have reached opinions --

A. Yes, I --

Q. -- and you had -- and in order to do that, you had to reach a certain point based on your review of the evidence where you had a high level of certainty; that's what you testified. And I'm trying to understand how to understand what you mean by "high level of certainty." So, for example, I asked you for a numerical and I don't -- and I didn't get an answer

Q. Potentially, but possibly not, right?
A. It could potentially work its way out or it could go the other way and lodge in the retroperitoneum.
Q. Right. So focusing on that specific scenario, we have a fracture. Let's assume it's asymptomatic. Patient doesn't feel any pain, doesn't come to the doctor and complain about anything, and it's embedded. One possibility, weeks later, months later, years later, is that it breaks loose and goes in the direction of the heart. Right?
A. That would be rare, but that could happen, yes.
Q. Right. And -- and so certain asymptomatic -- certain number of asymptomatic fractures can become life-threatening problems based on that dynamic of the blood flow in the vessel and -- and breaking loose from -- from the -- from the fractured element being embedded in -- in the tissue, right?
MR. ROGERS: Object to the form.
A. We believe that's a rare event, but that could happen, yes.
Q. And you read the -- the editorial that accompanied the publication of the Nicholson study by

organs and cause death or other serious injuries, right?

A. Well, one -- by that logic, migrating into the retroperitoneum would be better than migrating centrally into the blood flow and then embolizing to the heart, so it depends which migration we're -- we're trying -- we're discussing.

Q. But you don't want it to migrate to the heart, right?

A. That would be the least -- the least favorable location, correct.

Q. Where else would you not want it to migrate to?

A. I mean, theoretically the pulmonary artery, but that is even, I think, a rarer location to -- that it would -- for it to cause a complication.

Q. And why is it that you would not want a filter strut to migrate to the heart? What could happen that's not good?

A. That's not good? Because I think the majority of times -- nothing happens the majority of times. Rarely it can perforate the wall of the heart and extend into the pericardium and cause either a pericardial effusion or -- or hemorrhagic effusion - we

call it tamponade - or an infection theoretically. Those are extremely rare events, but that could potentially happen.

Q. And then what happens to the patient when that happens?

MR. ROGERS: Object to the form.

A. It theoretically could be a fatal event, but I think that is an extremely rare situation.

Q. And why would it be fatal? How could it be fatal?

A. Well, tamponade -- remember, this -- this wire is very small caliber.

Q. It's like a needle, right?

A. That's right. Needle. And it is -- I'm sorry. What was the -- what was your question again?

Q. Why would it be fatal? How could it be fatal?

A. Oh, theoretically --

MR. ROGERS: Object to the form.

A. -- it could cause bleeding. But I'd like to take that into consideration and compare that to techniques that interventional radiologists used all the time, including my father, who put catheters a hundredfold larger directly into the left ventricle to do coronary -- cardiac angiography prior to modern

techniques and simply pulled them out when they were done and put a Band-Aid on the skin, and the vast majority of those patients had no complication at all. So I'm trying to explain the difference between a tiny, tiny-caliber needle perforating the wall of the heart and a large-caliber tube perforating the heart.

MR. ROTMAN: So I move to strike the nonresponsive portion.

Q. But if you could look at the next -- the -- the right column of the page that we're on in this exhibit, and the sentence starting on line two beginning with the word "Assuming." Do you see that?

A. Yes.

Q. And read along with me, if you would. "Assuming that our data do not represent a statistical aberration, we suggest there are many other patients with Recovery filters with arm fractures and migrations in whom it is conceivable that these migrated fragments have gone undetected."

Okay? So I want to ask a question about your understanding of what -- how it could be that fractures and migrations could go undetected.

A. Because most of the time they're asymptomatic, so the patient's not going to have any symptom and

we'll never know that they even have a fragment until someone tells them based on a chest x-ray or some kind of scan that they have a fragment there, and in my experience, all of a sudden those patients then do develop symptoms because now they know they have a fragment.

Q. But as we established before, asymptomatic fractures and migrations can become life-threatening events?

A. Rarely.

Q. Rarely. In your opinion, rarely?

A. I emphasize rarely.

Q. Okay. Now, I want to -- I want to talk about how it could be that -- how it would present, this scenario that you describe where the patient could die from the -- from the needle in the heart, if you would, causing tamponade and bleeding and that -- that series of adverse events.

Let's assume a patient is at home with a Bard retrievable filter that was implanted eight years ago and -- this sequence of events in fact happened. And they're home, they're not in the hospital, they're not in a doctor's office, and they wake up dead; in other words, they -- this all happens and they die. Okay?

Q. Right. And you don't know as you sit here today whether that's happening all over the place every day or every week in this country and it's not being recognized but filter fractures are killing people and they're dying at home and nobody's connecting it to the filter?

MR. ROGERS: Object to -- object to the form and foundation.

You can respond.

Q. Did you just laugh?

A. Well, I'm trying to think of the scenario. I mean, that -- people die from many different reasons. That's, like, a negative question you're asking me, so how can I prove a negative if there's no evidence on a negative?

Q. You can just answer my question, which was, You don't know as you sit here today whether this is happening frequently and not being detected?

A. I don't know that --

MR. ROGERS: Object to the form.

Q. Right?

A. I don't know that it is; I don't know that it isn't.

Q. Right. And so you cannot say to a reasonable

degree of scientific certainty that this event is rare unless you know the answer to the question of whether it's recognized when it happens on a regular basis, right?

MR. ROGERS: Object to the form.

A. It's speculation.

Q. You don't know if it's rare or not, do you?

MR. ROGERS: Object to the form.

A. I -- that's really difficult to answer because we know from some of these observational studies that have filter fragments in their chest, the vast majority of them are asymptomatic and they're not reporting large numbers of deaths in their patient population, so --

Q. Now, in the middle paragraph of this Hull paper, you see that in addition to evaluating whether -- the condition of the filter, they were looking at these fractured filter parts under a scanning electron microscope, right?

A. Yes.

Q. And they did so and they made a determination that it looked like to them bending fatigue fractures, right?

A. That's what they say, yes.

Did I read that correctly?

A. Yes.

Q. So what does that mean?

A. It means that in a patient that has a fragment embolization and if they develop chest pain, clinicians evaluating the chest pain may be driven to evaluate them for coronary artery disease, which is much more common and a much more common cause of sudden death than a fractured filter component embolization.

Q. And you agree that that -- with that statement?

A. Yeah. And I certainly would think that that's warranted also because it is so much more common.

Q. But that very statement tells you to the extent that that's the case that there will be unrecognized patient deaths from filters.

MR. ROGERS: Object to the form.

Q. Because patients are having cardiac embolization and it's misdiagnosed --

A. Well --

Q. -- as something else.

MR. ROGERS: Object to the form.

Q. That's what this is saying, isn't it?

A. I'm still looking for a proven case of a

filter fragment embolization that's caused a death. Maybe there is. Maybe you know of one, but I haven't -- I haven't seen that in the literature or a case report of that, a proven case. I know Nicholson talked about sudden death at home, but again, there was no documentation that I could see that an autopsy proved that that was the cause of death. So I don't know what -- I don't know if it's frequent or not. I'm just saying I haven't seen any evidence to say that it is or isn't.

Q. I didn't say it was frequent. My question wasn't about whether it's frequent. My question was about whether these -- this statement is saying that people presenting with this problem are going -- are -- are frequently, commonly misdiagnosed, right?

MR. ROGERS: Object to the form.

A. It's speculation, but that's a possibility.

Q. In other words, the statement that you've made several times today about it being a rare event assumes that the events are being identified. You don't -- otherwise you don't know whether it's rare or not, right?

MR. ROGERS: Object to the form.

A. I think some of these observational studies

have shown fracture fragments in -- in numbers of their patients, and they have generally been asymptomatic, according to the papers. The Vijay article, for instance.

Q. Asymptomatic at one point in time.

A. True.

Q. Not necessarily remaining that way, right?

A. No one knows what happens 20 years from now, correct.

Q. So a patient comes to see you and you see that there's a fracture and they're saying, Well, I don't feel any pain. And you say, Okay, well, go home; come back in a year? Or do you say, Let's talk about what can happen and what we might do for you?

A. That has not been a scenario I have seen recently. My partner, though, did a month or two ago, and he did evaluate that patient in the clinic, also consulted our cardiothoracic surgeon, and they all agreed that that patient was asymptomatic and would just be followed clinically and that no attempt at removing that fragment would be made or indicated at that time.

Q. That would be a patient decision to be made in consultation with their doctor, right?

A. Yes.
Q. And did you review the report of Dr. Eisenberg?
A. Yes.
Q. And do all those reports that I just mentioned cite and quote extensively from various Bard internal documents?
A. And much of -- yes. And much of the verbiage is identical among all those reports.
Q. And in any of those reports, after reviewing what those experts had to say about those internal documents, did they change any of the opinions that you have in this case?
A. No.
Q. Doctor, you were asked several questions by plaintiffs' counsel where you were given hypotheticals about filter fragments traveling to the heart and causing possible consequences. Do you recall that?
A. Yes.
Q. And in your practice have you ever seen that occur?
A. Rarely, yes.
Q. And -- and so when you were testifying about those various scenarios, were you testifying about that

as a hypothetical situation?

A. Only, yes.

Q. And when you say "rarely," can you give us some sense of what that means?

A. Well, we've -- this is my best estimate that we've placed roughly 1,000 Bard retrievable filters over the years and we've removed -- I should know the exact number, but it's somewhere between -- at least 300 -- actually, it's probably now more -- you know, closer to -- over 300 of those filters, and we've only encountered four fractures of a Bard filter. We've seen other fractures of some of the other filters we've placed. And I only know of two cases where there was -- where there -- where there were fragments in the chest, one in the right ventricle and another in the -- several fragments in the pulmonary arteries.

Q. Doctor, to shift gears on you a little bit, do you recall being asked by plaintiffs' counsel to -- you were asked several questions asking you to quantify the level of certainty that you were giving for your opinions in this case. Do you recall that?

A. Yes.

Q. And prior to today, have you ever been asked in the course of your career to quantify the level of